

**TRANSCRIPT
TOWN HALL TELECONFERENCE**

**SECTION 111 OF THE MEDICARE, MEDICAID & SCHIP EXTENSION
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DATE OF CALL: November 10, 2010

SUGGESTED AUDIENCE: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation Responsible Reporting Entities- Question and Answer Session.

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Centers for Medicare & Medicaid Services

Moderator: John Albert
November 10, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Sean), and I'll be your conference operator today. At this time, I would like to welcome everyone to the MMSEA Section 111 Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question-and-answer session. If you'd like to ask a question during that time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I'd now like to turn the call over to Mr. John Albert. Begin your call, sir.

John Albert: All right. Thank you, operator.

For the record, today is Wednesday, November 11th. This teleconference is for the non-Group Health Plan implementation of the Section 111 Mandatory Insurer Reporting requirements. This call again is geared to the non-Group Health Plan which will be our Workers' Comp Liability No-Fault Insurers.

This is one of the continuing series of calls that we have been hosting over the past two years to get you accessed to CMS and simply get some of your questions answered that you submitted on the Resource mailbox.

The format will be of the other calls have been and that we will do some presentations here and then open up the floor to the question-and-answer session. We apologize for maybe starting off a little bit later. We had some issues in our end that prevented us from starting this call on time.

I just wanted to reiterate to everyone out there that while the production go-live dates are in 2011, that there are many MSPs that are currently in

production status in submitting full production files or partial production files to it.

And again, we encourage folks that are ready to submit data to at least begin doing so because there's no better way to fully test your reporting process in the Submit Live production data. Right now, we have almost 10,000 RREs that are actually in production status and have received at least one file from about a third of those so far.

So again, we thank those that have, as I've said the last time, have agreed to participate in this process as early as possible because the information that we end you gather from this process by exchanging production files will only make it better for everyone else in the long run.

I'm going to start off with the presentation by – Barbara, do you want to – by Barbara Wright and then Pat Ambrose and anyone else in the room has anything to add. But with that, I will turn it over to Barbara once I make the bonding disclaimer.

And that is, anything that we say on this call that contradicts the written materials on the Mandatory Insurer Reporting Web site, the stuff on the Web site actually takes precedent of what we speak on this call. If there is a conflict, we always try to make sure that anything comes out on these calls is updated in the materials as needed but again, if there is something stated on the call that contradicts form; written guidance in the User Guide or some of the alerts, that information on the Mandatory Insurer Reporting webpage takes precedent over we way on this call.

So with that, I'll turn it over to Barbara Wright who has a brief announcement.

Barbara Wright: Thanks, John. I wanted to make a brief announcement at the beginning of the call. We've received several requests for a delay in the all of the reporting or some aspect of the reporting for NGHP.

And CMS has received all those requests. They are under considerations. CMS will make its position known on the request very shortly on the Web

site. We will not take any questions on this issue so we wanted you to know that it is under consideration and that you will have the answer very shortly.

Second point I wanted to make is we received from more than one source a lot of rumors about asbestos resolution. There are apparently some attorneys whether they're all plaintiff's attorneys or whether some are defense. I don't necessarily know but there are statements about CMS engaging in a protocol to resolve all liens for asbestos cases or at least for all non-malignant liens.

CMS has no such national process that it's working on. As per our usual process, we are engaged with some entities for global resolutions of particular universes of claims. If you hear rumors or allegations about some type of national process, you should not place a lot of weight in those. If they are talking about working with a particular entity, it might be who of you to go to that entity and find out what it's engaged in. But we don't have any national process that we're working on here.

A couple more things before we go to Pat Ambrose. I've asked (Bill Ravornia) to go over briefly what our general rules are for illness-specific insurance, accident insurance and occupational insurance or accident and occupation because we keep hearing the same questions repeated on those issues. So (Bill), could you briefly address that?

(Bill Ravornia): OK. The specific illness insurance, these are sometimes called the indemnity-type policies, may or may not be MSP depending on the circumstance. If there is employer involvement, (inaudible) offered through an employer, the employer is paying the premium, the employer is reimbursing, the employee for the premium or the employee who is merely collecting the premium and forwarding it to the insurer then it is considered a Group Health Plan and the MSP rules are applicable.

However, for the specific illness policies, they are not reportable at this time but you still need to follow the MSP rules. I had not seen an indemnity specific illness policy that I would consider to satisfy the definition CMS's regulations concerning Workers' Compensation No-Fault or Liability.

It does mean that there isn't something out there that would satisfy those definitions. I am just not familiar with it. If someone has such a policy, they would share it with us. We go – we'll take a look at it.

What's the second one? Third one I know is occupational health. (Hold) this general accident policy.

Barbara Wright: Illness-specific accident insurance, occupational insurance and if it's called accident and occupational.

(Bill Ravornia): The typical accident policy that I'm thinking people are referring to is the policy that someone takes out that basically says, "If your insured and this policy is going to pay, you know, for your treatment to the even that "other insurance may not pay or may not have that caveat." First, there is not considered other insurance and in most cases, those things would be considered no-fault insurance.

However, I have seen certain things where they're calling it accident insurance where it's being offered to patrons of a particular event that – events that they're injured at that event, the sponsor will pay for their care – for their treatment. That's really more of a risk management type institution in a liability context or I would generally consider those to be a liability policy.

And the occupational accident, policies are generally for self-employed truckers which basically say they're going to pay for accidents, healthcare and sometimes other things for truckers who are injured in an accident whether they are the cause or not. Those satisfies CMS' definition of the no-fault insurance and are considered by the agency to be no-fault insurance.

Barbara Wright: Thanks. OK. A couple other questions that we've got multiple questions on the same issue is we received two or three that had to do with risk management write off and they had to deal with how this should be dealt.

This call – it's outside the scope of this call to give billing instructions for providers and suppliers. CMS' existing instructions for how to bill in a situation where Medicare is secondary are already available on various sites.

If you have a question about billing in your provider or supplier then contact your claims processing contractor with your specific question.

Let's see. There were also several questions that really went to the issue of when reporting needs to take place. There was a consistent argument. "Well, we don't believe any medicals were paid so that means we don't have to report, correct?"

And no, that's not correct. Again, we're looking at where medicals are claimed in or released. The fact that you believe that there may not be any claims because you haven't received any doesn't mean that Medicare did not receive any claim.

So as a general rule, as we've said on prior calls, we're looking at which claims are released. We're not looking or where settlement has the effective releasing medicals. We're not looking at you to determine whether or not there were any actual medical services associated.

Let's see. And at least two questions specifically asked whether psychological treatment had to be reported. And again, Medicare does pay for psychiatric and psychological treatment. So there would be no reason that those would particularly be an exemption in reporting.

And with that, I'll turn it over to Pat.

Pat Ambrose: OK, thanks, Barbara. As you know, we only have one NGHP town hall this month and also one next month in December. So we're covering both policy and technical issues. And I obviously am going to cover the – some of the technical issues that hopefully will answer some of your questions about reporting and make sure that you're ready to commence production reporting in first quarter 2011 if you haven't already done so.

First off, there are a couple of recent postings on the CMS Mandatory Insurer Reporting web pages at www.cms.gov/mandatoryinsrep. On the NGHP Alert page, you will see two alerts both dated October 14th.

The first refers to reporting timeline and it is giving instructions on the timeliness of reporting. NGHP TPOCs or a Total Payment Obligation to the Claimants is basically stating that this should be done when the RRE has the adequate information about who will get paid and how much. Again, I refer you to that alert dated October 14th on the NGHP Alert page.

The other has information on how to go about calculating the date of incidents for situations that involves a cumulative injury.

Also note that we continue to update and add additional Computer-Based Training modules. CBTs can be – you sign up to take the CBTs. They are offered at free of charge. Again, go to the mandatory insrep webpage and click on the CBT link or tab on the left-hand side and that will take you to a page that gives instructions on how to sign up for the Computer-Based Training.

Just a note about recent editions that we've made to the course curriculum, for Direct Data Entry, we have a couple of courses out there. One is DDE Using the Section 111 COB Secure Web Site.

This module provides an overview on NGHP Direct Data Entry or DDE. It explains the NGHP DDE reporting requirements and provides information on how an NGHP RRE can get started with this reporting method.

There is another one entitled, "Switching to or from Direct Data Entry". This explains the process an NGHP RRE must follow when switching to Direct Data Entry from a file submission method. It's intended for NGHP RREs that have already completed the registration and account setup processes.

NGHP RREs that have not yet registered or completed account setup should review the standard CBT Section 111 registration Part 1 and 2 and the COB Secure Web Site Step 1-New Registration and COB Secure Web Site Step 2-Account Setup.

We have made some updates to the version – to the CBTs based on Version 3.1 of the User Guide and continue to work on other updates. Some that have

been released for Version 3.1 include the data transmission method selection and the COB Secure Web Site Step 2-Account Setup.

There are more Direct Data Entry, CBTs, plans. There'll be one entitled, "DDE Screen Overview". That's anticipated to be released next week. We also anticipate to release two courses related to ICD-9, some frequently asked question-and-answers and ICD-9 reporting requirements.

Again, we anticipate posting those next week. If you're registered for the CBTs, you'll get an email when any new courses have been added or existing courses have been updated. We expect later this month to post updates to other courses based on version 3.1 of the User Guide.

As we've talked about on previous calls, we've implemented a change to accept ORM termination days that are less than 30 days greater than the date of incident. A modification was made to the CJ06 edit for this.

Note that the requirement concerning ORM termination dates that are more than six months in the future will remain the same. You still may not post an ORM termination date that is six months in advance of the current date. So that as a part of the CJ06 edit remains the same.

However, we have removed the restriction and you may send us an ORM termination date that is less than 30 days from the date of incidence. This change has gone into the production environment.

We have change of plan for the system. As I've mentioned on the last call, do not allow numbers or numerals in the (CD) address fields of the representative claimant and claimant representative address fields. Again, please modify your systems not to submit a number in any part of the (CD) fields.

This change will be made prior to January since it's causing us some internal issues interfacing with other systems here at CMS and in the Medicare systems. I don't have an exact date when it will be implemented though.

Other upcoming alerts related to technical issues that are pending being posted on the Web site include information about a default ICD-9 code that maybe

used under very restricted and specific circumstances. That default code will be five positions and the letters and NOINJ. Again, alert is – an alert is pending for that and an alert is pending to provide more information on Workers' Compensation indemnity payments.

Also, on the last call, we've discussed changes to the address validation on the TIN reference file. Currently, the system posts – or will return an errors for certain problems in the address fields on the TIN reference file.

In the January release, we are changing that to actually accept the record but return compliance flags for specific circumstances, so in other words, we're replacing certain error codes with compliance flags. There – again, there is an alert pending for that. It should be posted very shortly.

Let me read off the list as I did in the last call for the error codes that will be affected. Basically, it's error code CT14 through CT23. So that's CT14, CT15, CT16, CT17, CT18, CT19, CT20, CT21, CT22 and CT22. Those error codes will be disabled and replaced with compliance flags, and please review the section in the User Guide on compliance flags.

Any claim records associated with address as it have problems will be returned with compliance flags and the RRE is expected to fix those problems and resubmit the address for that, the associated TIN, in the next quarterly file.

In addition, we will post an alert onto notifying you of the retention of old ICD-9 codes. Again, we've talked about this on prior calls. Once an ICD-9 code is considered valid, it will always remain valid. So if it was accepted on an Add Record and you submit an update for that record down the road, that ICD-9 will continue to be accepted.

Now, related to system changes, our January 2011 release date for Section 111 is January 7, 2011. So that means that files submitted and processed before January 7, 2011 will be processed under the old or existing rules, and files submitted on January 7, 2011 and subsequent will be processed using the new rules.

If you have concerns about, if your file submission period is that first week in January 2011 and you have concerns about submitting the file and having it processed under the so-called old rule then please contact your EDI representative. I'm pretty sure that we would accept a later submission of your file if you have concerns.

I don't think that there is anything that significant that, you know, would result in a high rate of rejection of your records or anything like that, but please note though that our January release date is January 7, 2011.

That also means that the Direct Data Entry will not be available on the COB Secure Web site until Monday, January 10th. It might actually be available a little bit earlier depending on how release activity over the weekend goes but count on it being available first thing Monday morning on January 10th, 2011 for Direct Data Entry.

Now, we've had some folks looking at, as John mentioned earlier, we have been receiving production claim input files and processing them and returning claim response file, and we have some folks that have been looking at those files and common errors and I'd like to mention a few of those to help not only those that are reporting in production now but those that plan to start their production reporting in first quarter 2011.

A first very common error that we're seeing is the CI05. This relates to the ICD-9 diagnosis code 1 or Field 19. Invalid codes are being submitted in Field 19. Several situations occurred where the ICD-9 code must contain four or five digits but RREs are reporting only three digits.

For example, ICD-9 diagnosis code 389 or 3-8-9 has been submitted. DX code or diagnosis code 389 is not actually valid – 3-8-9-space-space is not a valid ICD-9 code. All ICD-9 code start with the numerals 389 have either four or five digits. For example, 389H or 38901.

Again, make sure that the ICD-9 diagnosis codes you're submitting in Field 19 and any of the other – Field 15 and any of the other diagnosis codes field subsequent to Field 19 match exactly the first five positions on the text files of ICD-9 as listed in the User Guide. You've had to have an exact match.

Yes? I'm sorry, I have to put us on mute for a minute.

Actually, it's been suggested here that perhaps the individual who is entering the ICD-9 code without the valid number of digits is seeing the decimal point and thinking that they could drop the numerals after the decimal point in the ICD-9.

Now, as you know, you're not to submit ICD-9 codes with the decimal point but those digits after the decimal point are to be submitted and are critical.

Barbara Wright: Even if there zero.

Pat Ambrose: Yes, even if they are zero. So yes, don't drop your leading zeros, don't drop the trailing zeros, et cetera.

Our next – another common error that we did see was the CJ06 related to termination dates that are less than 30 days after the CMS date of incidence. RRE should not longer be receiving this error, and if you do and you believe it's erroneous, please report that to your EDI representative.

Another common error we're seeing is the CJ07 error. This relates to the TPOC threshold. Add Records are being submitted where the ORM indicator equals N, that's Field 98, but the TPOC date Number 1, Field 100 and the TPOC announced 1 in Field 101 both contains 0s.

It does not make sense to submit a claim input detail record with an ORM indicator of N and no TPOC information. So perhaps, you need to either set the ORM indicator equal to Y or provide obviously adequate TPOC information or you may need to go back and do a little bit more review of the User Guide.

One of the questions we've got or received since the last call was asking about a situation where there has been a verdict for the defense and absolutely no payment was going to be made, and in that case, they wanted to know whether or not they had to report a TPOC of 0. No, you don't report TPOC of 0.

Another common error that we're seeing is CP04. This relates to the policy number in Field 74. Some RREs are leaving this required field blank. Note that in the case of self-insurance and RRE not actually having a policy number, that that field should be field with 0s. All phases will not be accepted and is not considered valid.

So obviously, if you're an insurance company RRE reporting, you would have a policy number and it's important to include an accurate policy number in that field along with the claim number in the claim number fields.

But if you do not, if you're self-insured and you do not retain policy and claim numbers then please populate those fields of all 0s and review the file layout – and the field description and the file layout for those fields for the default.

Another common error that we're seeing is CS02. This is the self-insured type or Field 65. RREs are submitting the self insured indicator in Field 64 of meaning not self-insured but then are entering a value of O in the self-insured type Field 65.

If the value you use in the self-insured indicator Field 64 is N then Field 65 should contain a space. Since you're indicating there is no self-insurance or it is not a situation of self-insurance then obviously, you should not be reporting a self-insurance type. So Field 65 is only applicable if the value in Field 64 is a Y. Again, please review the User Guide and I'll see what adjustments I can make to those field description to make it more clear.

We've added -- so that's it for the lessons learned so far. Obviously, we're seeing other things. Please work closely with your EDI representative to get your questions answered and continue testing.

We are adding a new bulletin board feature to the Section 111 COB Secure Web site. Announcements related specifically to the Section 111 COB Secure Web site or COBSW and the Secure File Transfer Protocol or SFTP are now being posted on the homepage of www.section111.cms.hhs.gov. That's the URL for the Section 111 Cob Secure Web site which obviously is in the User Guide as well.

Near the top of the page – after you click on I Accept on the wording page and you display the homepage, near the top of that page, you'll see label Section 111 messages and in particular you'll see messages that will announce scheduled outages of the Web site for maintenance, both the Web site and the Secure FTP server. And then also when we have an unscheduled outage that will be announced there and the status of the correction will be provided.

So hopefully, that will provide you some additional information if you're having trouble with the Web site to see that something is happening and it's being worked on. If you don't see an announcement there and you're having a problem, obviously, report that to your EDI representative as soon as possible.

I want to do some follow-up to the 10/28 call where a question was asked about health insurance claim numbers. Medicare Health Insurance Claim Numbers or HICNs, beginning with the characters H0, we have some questions about specific HIC Numbers or HICNs beginning with the characters H0.

And when this type of – when a HIC Number beginning with H0 is submitted or used with the HEW Query Software, problems arise because it looks like rather than a detailed record, it's a header record. And actually, we had answered this before but on the last call, we couldn't remember so I went back and looked it up.

At one time, there were certain railroad beneficiaries that had Medicare Health Insurance Claim Numbers that began with the characters H0, however, our analysis of this situation is that this – well, we do know the numbering scheme is no longer used and our analysis of the situation is that there should be no current living beneficiary with HIC Number starting with H0. And so, we also assume this range will never be used again going forward.

So my recommendation to you is that if you have a HIC Number starting with H0, it is either inaccurate or belongs to someone that is no longer alive. And associated claim record would not likely be reportable given the reporting dates.

If you must query a person for whom you've been given a HIC Number starting with H0 using that HEW Software then I suggest you query using only the social security number.

And if you have troubles with your query and what you do, again, contact your EDI representative, and as always, please submit your specific technical question to your Edi representative first that they're in the best position to handle those technical questions and you'll get the most immediate response. If you have trouble with that process then see Section 18.2 of the User Guide and escalate your issue as necessary.

OK. I'm also going to discuss some of the – go over some of the questions that have been submitted since the October 28th call. The first one asked is the plan – if CMS still plans on moving ahead to have production reporting begin January 1, 2011 and yes, the plan is still to begin production reporting January 1, 2011. RREs are to report during their assigned file submission timeframe in first quarter of 2011.

The next question went on, and I believe Barbara already covered this, it was about once you report ongoing responsibilities for medicals and should the RRE wait to see if they receive a medical claim before they report ORM. And that is not correct. RREs are to report ORM as soon as it's assumed and not wait to receive an actual medical claim for medical services for the injured party.

The next question was asking – or next part of this question was asking about, this RRE is only submitting query records at this time. They have not transitioned to production claim reporting but they've gotten report for the Medicare beneficiary. It is stating that Medicare is denying certain medical claims and certain drug claims submitted to Medicare and due to a claim report made by the RRE.

And in this case, it's not possible since the RRE has not started submitting claim reports. We don't do anything with your query files other than return a response file indicating whether that individual is matched to a Medicare beneficiary.

So – but please note that there are other sources of information for Liability Worker's Compensation and No-Fault claim reporting. These other sources include the beneficiary themselves. The beneficiary' attorney or other representative could have a report of this. It's possible that even another insurance company has made a report.

So be aware again that we're not doing anything with your query file but your claim could have been reported to the COBC for Medicare to use in claims payment related and been reported by an attorney or some other entity.

Barbara Wright: Also, claims processing contractors should not be denying claims that aren't related to what's being claimed or released simply because we have some type of open records.

So if that's happening in particular case, it is an error that they need to work with the – the beneficiary needs to work with their claims processing contractor to get that straightened out.

If claims are related, there are promptly requirements and if a matter is in dispute and documentation of that is given to the claims processing contractor then they should go ahead and pay related claims conditionally.

Pat Ambrose: OK. Thanks, Barbara.

And the next question has to do with Direct Data Entry and asking if we have a form available for RREs to assist them in capturing information that they will need when they go – they come to the Web sites to do their Direct Data Entry for claim reports.

We do not have such a form but I need to refer you to the file layout and corresponding field description in the User Guide. Those same requirements apply to Direct Data Entry. Even though you're not submitting a file, all the same basic data elements are being collected and the requirements and what you need to collect as you're processing your claims and set aside for your Direct Data Entry, those requirements are reflected in the file layout and field descriptions in the appendices of the User Guide.

The next question went on to talk about an incident where a Medicare beneficiary files a claim – that claim for slip and fall. And the RRE settles that claim and reports that claim to us with the appropriate TPOC information.

Later on, two years later, the beneficiary injures himself and it turns out that – or injures himself again, it's not related to the prior claim but some of the diagnosis codes happen to match.

So let's say in a slip and fall, they sprained an ankle and that RRE reported the appropriate diagnosis code for that, subsequently, the beneficiary in some other unrelated incident, unrelated accident sprained an ankle again, the RRE is concerned that their original claim report will affect Medicare's claim payment for the second injury.

And if the settlement day of your original claim is prior to the date of incident, date of service, for the second injury, your original claim will not be considered by Medicare. It wouldn't have any relation to it when Medicare is considering payments for the medicals related to the second later incident. So there are no issues there. We're or not only keeping track of your claim reports by ICD-9 diagnosis code but also the date of injury and the date of your settlement and so on.

Another part of this question asked about, ICD-9 codes are related to noise-induced hearing loss and the individual was confused about what ICD-9 codes to submit. We'd like to refer you to the 388 series of ICD-9 code. They should be appropriate.

So ICD-9 codes beginning with 388, again, make sure that you match, you know, the first five spaces in the list of valid ICD-9 codes, but take a look at the 388 series for noise-induced hearing loss.

The next question asked about monitoring a claim for which the RRE has ongoing responsibility for medicals and that ORM continues indefinitely because of certain state laws where the RRE must assume or retain responsibility for medicals for the lifetime of the individual or some extended period of time.

And in their circumstance, they have an injured party who is not yet a Medicare beneficiary and might be actually very young and wouldn't have the potential for being a Medicare beneficiary for quite some time.

I remember there is other reason for becoming entitled to Medicare other than just your age, ESRD and disability can also entitle you to Medicare under proper circumstances.

So at any rate, there are instructions in Section 11.8 and in the Section that discusses how to react to disposition codes that you get back on claim report, and you must continue to monitor the Medicare status of an injured party until ongoing responsibility for medicals or M is terminated.

There are currently no exceptions other than what is currently documented within the User Guide now so again, I refer you to Section 11.8 for more information on that.

Let's see. Someone pointed out that error codes SP48 and SP49 have exactly the same description and they – and that is correct. These error codes for non-GHP RRE's purposes are exactly the same. These error codes are actually returned to the COBC from another system and then we pass those back to you.

Both error codes indicate that you have submitted a delete transaction that we cannot match to something that you've submitted previously. So either the record was already deleted or there is a problem with the matching fields – the key fields that you're submitting, but the User Guide is actually correct for error codes SP48 and SP49 and you should take exactly the same action when those error codes are returned.

Another question was asking about, one of their managers asked, "I would like to know if the Medicare beneficiary elects one of the outside providers for their healthcare. Are they still given a Medicare ID card with HICN?"

And this relates actually to the question with HIC Numbers beginning with H0 and this individual was trying to find, you know, a possible explanation.

Again, the H0 HIC Numbers were assigned originally by to railroad board Medicare beneficiaries.

But the answer is no matter what – whether an individual enrolls in Medicare, the standard Medicare Part – fee-for-service Part A and B or if they’re in a Medicare Advantage plan. If they are a Medicare beneficiary, they will receive a Medicare ID card and that Medicare ID card will have an HICN or HIC Number.

Male: And (inaudible) remind everybody that we don’t issue Medicare ID numbers here at CMS. They are issued by the Social Security administration and only the Social Security administration. Private entities do not issue Medicare ID numbers.

Pat Ambrose: And obviously, a Medicare beneficiary that has other insurance coverage and other group health insurance coverage, they are going to get – that other insurance company is going to assign that individual an identifier so there might also be a confusion where a Medicare beneficiary provides that identifier as opposed to their Medicare IDs so I’m not sure, you know, what could be going wrong. But – and anyway, if they are Medicare beneficiary, no matter which plan they’re enrolled in, they’ll have a Medicare HICN.

The next question was asking when – if they receive a response – an RRE receives a response file indicating errors, how long do they have to correct it and does it have to be within our reporting window?

When you received errors back on your response files, you are to correct those records and resubmit them in the next quarter during your assigned file submission timeframe. So again, you are to correct errors and resubmit the affected records on your next quarterly file submission. You’re not expected to do it within that seven-day window of the same reporting quarter. You’re doing it – you’re making your corrections and sending then to the next quarter.

Again, during your file submission timeframe, note that DDE or Direct Data Entry submitters can correct issues right away though as they don’t have a file submission timeframe since they’re now submitting files. But for RREs, if

they're submitting files, make those corrections and submit them in the next quarter.

Another question was asked about if an injured party was diagnosed with more than one disease over the years, do we include all such ICD-9 codes or only the disease for which he or she settles and receives payment?

I refer you to Section 11.2.5 of the User Guide where one of the bullet points under ICD-9 reporting requirements states that when there is TPOC settlement adjustment award or other payment, RREs are to submit ICD-9 codes to reflect all the alleged illness injuries claimed and/or released.

Where ORM is reported, RREs are to submit ICD-9 codes for all alleged injuries or illnesses for which the RRE has assumed ORM. So I think we have answered that question in the current version of the User Guide.

The next question had to – relates to ORM reporting and this individual is asking if they understand correctly, they do not report dollar amounts when terminating ORM unless there was also a TPOC settlement or a TPOC established at which time we would report the TPOC settlement amount only.

So in the case where you have reported the claim with ORM, with the ORM indicator equals Y and then you are reporting a termination of that ORM, you would again report the ORM indicator equal to a Y. It would report an ORM termination date. And if there is an associated TPOC amount U on the same transaction record, you would report the TPOC amount and the TPOC date.

If it's a No-Fault claim, you would also be reporting those No-Fault exhaust date field as well. I don't know the name off the top of my head but they're obviously listed in the file layout.

This question went on to ask about Worker's Compensation ORM claim and if they could submit all their Worker's Compensation ORM claims even those that are – that fit the exception or the exclusion listed in Section 11.4 of the User Guide where the Interim Reporting Thresholds are documented.

You can, in fact, report all Work Comp ORM without regard to the Work Comp ORM threshold described in Section 11.4. Basically, the system has no way of knowing whether those conditions for Work Comp ORMs have been met or not.

Now, I'm only talking about Work Comp ORM. I am not talking about the TPOC thresholds in this answer.

Obviously, if you read further in that Section 11.4, you'll see that under certain circumstances that the claim keep – the TPOCs on the claim reported do not exceed the threshold, your claim will actually be rejected.

I don't know if you want to answer Part III...

The next question had a situation – Barbara already covered this one. It was a suit that was settled and with no TPOC amount, and obviously that claim is not reportable and, you know, for many reasons but it does not need the TPOC thresholds for one.

The next question was asking or the last question I'm going to cover is on the last conference calls, we stated that there was an updated listing of the error codes and this individual wanted more information on that.

The error codes and the compliance codes related to your Section 111 reporting are in – obviously, in the User Guide. There are also Excel and test files that contain just the error codes and corresponding error code descriptions that match what's published in the User Guide.

The Excel and text files are posted for download on the Section 111 COB Secure Web site, so that's www.section111.cms.hhs.gov. These files can be found under the Reference Materials Menu option, and when you click on the Reference Materials Menu option, that drops down and select the link for error code data for NGHP RREs. And if you have trouble finding anything like that, again, contact your EDI representative.

So with that, I will turn it back over to John Albert.

John Albert: OK. Operator, we're ready to the Q&A portion of the call.

Operator: At this time, I want to remind participants, in order to ask a question, please press star then the number one on your telephone keypad.

It is required by management that you limit your questions to one question and one follow-up.

Your first question comes from the line of Bonnie Mustarde from Farmers Insurance. Your line is now open.

Bonnie Mustarde: Thank you for taking my call. I have a question. We are continuing to get messages for claimants' attorneys that they want to transfer our Medicare obligations to them via Hold Harmless Agreement. And I would just like to ask that you reiterate your position on that again?

Barbara Wright: When you say transfer Medicare obligations, are you talking about reimbursement obligations, the reporting obligations, everything part of that?

Bonnie Mustarde: Not reporting. It would be in terms of the lien. They want to hold the funds in trust until the claim is settled and Medicare advised their lien amount.

Barbara Wright: OK. As we've said before, you cannot transfer your MMSEA Section 111 reporting responsibilities nor is there any reason that we would recognize a transfer, an alleged transfer of any other responsibility.

It's not up to us. Whatever you wish, claimants and defendants wished to arrange. If they wish to arrange some type of indemnification agreement, we don't object to that but that indemnification is not binding us. If we had some reason to contact the insurer about something, we would still do that.

I will tell you that in most instances, before Section 111 reporting existed, it was routine for insurers to release funds to attorneys and they held them in their escrow accounts or they're taking care of the claim.

As we've said before, we don't have any intent to change our normal process in a liability situation of pursuing recovery against the beneficiary's settlement

judgment award or other payment but we can't give you legal advice as to whether or not you should agree to some type of indemnification agreement.

Bonnie Mustarde: Thank you. I just want it documented in the transcript today. I appreciate it.

Operator: Your next question comes from the line of (Susan Conruth) from New York. Your line is open.

(Susan Conruth): Hi. I have a couple of questions. One is do we need to send a Delete Record directly followed by a Add Record for changing one of the fields because – and then I'd also ask, what if one error is out and the other doesn't finished processing?

Pat Ambrose: Then you should continue to process the record that errors out. You can submit them in the same file and actually, the order of those records is immaterial.

(Susan Conruth): OK.

Pat Ambrose: And, you know, essentially, let's supposed the delete fails and the Add Records was successful, you'll essentially have two versions of the claim out there until that delete is unsuccessful so.

(Susan Conruth): OK. So it's not – so we just submit the delete in the next quarter?

Pat Ambrose: Yes, yes, I mean normally, you do it in the same file and the same quarter but if one fails and just the one that fails, just resubmit it the next quarter.

(Susan Conruth): OK. And...

Male: Just make sure you delete the record. It's supposed to be deleted.

Pat Ambrose: Right.

(Susan Conruth): OK. Another thing, with the TPOCs, we had answered questions a few months ago, I guess, about whether they must remain in the original fields reported and there was an issue of – I think one of the examples said no, one said yes.

So that if we had in report two TPOCs, we would need the, you know, regular record and the auxiliary file. But if we remove the initial TPOC, do we still have to keep sending you auxiliary file?

Pat Ambrose: That – you know, we did ask that you keep it that way so that we, you know, so that we were sure to update the appropriate fields. You know, in the end, if you were to – what you need to have is report the records with – you know, what I would do is report an update to zero out the first one and include your auxiliary record.

And actually on subsequent updates, you probably could move the TPOC2 to the TPOC1 but we really ask that you keep those positional and you have to continue to submit the auxiliary record but I'm pretty sure it would work if you move 2 to 1 and then on later transmission, stops sending the auxiliary.

I want to – I actually want to go back and verify that myself because it's been awhile since I'd thought about it.

Barbara Wright: So we're hopefully – unless this is a record that also involves ORMs. We shouldn't be seeing very often our TPOC record that needs to have TPOC deleted.

Pat Ambrose: Right, right.

(Susan Conruth): OK. Can I ask one other thing?

Pat Ambrose: Sure, go ahead.

(Susan Conruth): All right. Are we correct in assuming that only for a Delete Record we should submit all the same information from the last accepted record?

Pat Ambrose: That's correct. There are certain edits that are not performed on the delete such as ICD-9 editing but many – most of the other edits are performed on the delete transaction.

(Susan Conruth): OK. So all the information, the last accepted record should be resent for a delete, but for all the other scenarios, right?

Pat Ambrose: Yes.

(Susan Conruth): Position codes of 50, if we get an interrupt date, we can submit the current claim info?

Pat Ambrose: Yes.

(Susan Conruth): OK. All right.

Pat Ambrose: I mean technically on the delete, it doesn't have to match exactly what you sent either. You could – on the delete, you could send your most current claim information.

(Susan Conruth): As long as your key fields match.

Pat Ambrose: Exactly, because, you know, what you're really doing is just trying to get pass the edits so that the delete can be processed.

(Susan Conruth): Right.

Pat Ambrose: So, you know, you actually could send the most current information and again, as long as your key fields match.

(Susan Conruth): Right. OK. Thanks very much.

Pat Ambrose: Welcome.

Operator: Your next question comes from the line of (Rhonda Thomas) from Ireland Insurance. Your line is open.

(Rhonda Thomas): Hi. My question is on that query response files, we seem to get a lot of hits on just about every claim that we submit even if they are not age 65 or meet any of the other, you know, disabilities.

And I was just wanting some clarification on who is a beneficiary? It looks like it's not just a person that is 65 or older and meeting some of those other conditions.

Pat Ambrose: On the front of the User Guide, we provide some information – general information about Medicare and reasons for entitlement and certainly, you can find more on the general pages of the CMS Web site.

But individuals can be entitled due to having end-stage renal disease. They can be and so not be 65, be less than 65. They can also be entitled due to disability and, you know, that can also would be for individuals prior to turning age 65.

You should not – you know, now, if you're sending your query records for injured parties that have indicated that they are Medicare beneficiaries then you should expect the high rate of positive responses back.

But if you're sending individuals that you do not believe are a Medicare beneficiary and you get a match then I would report those specifics to your EDI representatives to research. So make sure you report them in a secure fashion. Contact your rep about how to do so if you're unsure, but, you know...

(Rhonda Thomas): I think you've answered the question. There must be a problem somewhere because like I was saying, some of my claimants that I know are not 65, they don't meet any of the other disability standards, they are not receiving Medicare benefits and yet, I'm getting a hit coming back on my query response file.

Pat Ambrose: Yes. It might be – now, remember, and you might – well, you know, I don't know what's going on. I've not heard this reported...

Male: By anyone else.

Pat Ambrose: ...by anyone else.

(Rhonda Thomas): I'll give you a little insight. The vendor that is sending our – that we've contracted with to send our files, they've said it's because of possible relationship with a Medicare or possible Medicare beneficiary. In other words, I'm under age 65 but – and my mother is...

Pat Ambrose: Now, you know, you need to make sure that your vendor is submitting the information for the injured party, only submitting either their Medicare HIC Number or their – the injured party's SSN and then we will only be matching it to – and their name and only matching it to them.

Now, sometimes a HIC Number can come back and it contains a social security number for the spouse, but don't get bogged down and out. What you send is information for the actual injured party and that's what we're matching against.

(Rhonda Thomas): OK.

Pat Ambrose: And, you know...

(Rhonda Thomas): ...I get it from the User Guide but that's just not what I'm saying in my response file.

Pat Ambrose: Yes. I think I need to report it to your EDI representative to look at the specific examples. They probably could get to the bottom of it very rapidly.

(Rhonda Thomas): OK, great. Thank you.

Pat Ambrose: OK.

Male: But on the assumption, there are vendors submitting either Medicare ID numbers or Social Security numbers. That's all we will be looking at.

(Rhonda Thomas): Right. That's what we were submitting which is the Social Security numbers.

Male: Right. So they're telling you that those are being related to some other person?

(Rhonda Thomas): Yes. They're saying that...

Male: That's highly unlikely.

(Rhonda Thomas): ...relationship to possible Medicare beneficiary. And like I said, I never saw that in the guide anywhere and...

Pat Ambrose: Yes. I think where the confusion might be is that, again, take a situation of a husband and wife, the HIC Number assigned to each might be using in both cases the husband's SSN but then the suffix would be different. The husband would have a suffix on his HIC Number of A and the wife or spouse a HIC Number with a suffix of B. they both start with the same number but I don't – you know, at any rate, as we've said, there is some confusion there and I think you should contact your rep about it.

(Rhonda Thomas): OK. Thank you.

Operator: Your next question comes from the line of (Carol Sombe) from (Vener Health). Your line is open.

(Carol Sombe): Hello. I have a question about people who are signing our release, releasing medicals, they're not the main injured party. And our understanding is that if they sign a release and a general release when the injured party gets money if their spouse or child or whatever, they sign a release also and they are Medicare beneficiary then we need to report them either with whatever medicals they have claimed or possibly with that no injury code that you're talking about.

Then my question is, if the claimant has expired and we are listing the claimants to our receiving TPOC and they are signing a general release, do we need to – if they are a Medicare beneficiary, do we need to also report them?

Male: ...where they sign – the person or representative of the state?

(Carol Sombe): They're claimant of the – you know, listed as a claimant.

Barbara Wright: But they are the injured party. They're not...

(Carol Sombe): They were not the original injured party. They are listed as a claimant for the injured party.

- Barbara Wright: They are claiming or releasing injuries to the injured party, not to themselves, correct?
- (Carol Sombe): Sometimes there is a general release where they are releasing their own medicals.
- Barbara Wright: If they are claiming or releasing medicals then you have a separate injured party. If they are simply doing on behalf of the deceased beneficiary then what you're looking at is medical claim that's released by the beneficiary.
- (Carol Sombe): OK. So we're going to report them once as a claimant with this TPOC amount and then if they release their own medicals then we're going to report them again and use that same TPOC amount.
- Male: You're going to report the injured party.
- Pat Ambrose: Right.
- Male: And then you're going to report the other party (inaudible) injured as well.
- Pat Ambrose: Right.
- (Carol Sombe): I mean it's going to look like dual, you know, dual TPOC.
- Barbara Wright: If we get something that appears to be dual that will be something that will have to be straightened out on the back end.
- (Carol Sombe): OK.
- Pat Ambrose: I'm sorry, go ahead. Could you repeat that?
- (Carol Sombe): I'm just asking – so we will report them as the claimant of the expired patient and now it will be that TPOC amount and then we will turn around if they were Medicare beneficiary and signed a release of their own medicals and we'll report them again and use that same TPOC amount.
- Pat Ambrose: And on that second report, if I'm understanding it correctly, Barbara, is she then reporting the surviving survivor as the injured party in that case? So in

one case, the deceased beneficiary is reported as the injured party and then the second claim report, the survivor – surviving spouse or whatever is reported as the injured party if they are indeed a Medicare beneficiary. And Barbara is saying, yes, the same TPOC amount in both cases. If they – now, again, if they've released claims under a released medicals for themselves.

(Carol Sombe): Right. OK. All righty. Thank you.

Operator: Your next question comes from the line of (Monsour Barmo) from Vinson & Elkins. Your line is open.

(Monsour Barmo): Hi, good afternoon. My question is with regards to how Section 11 applies property damage claims when the Medicare beneficiary solely sues for property damage but nevertheless, the settlement includes a general release.

I know that – I looked in the User Guide and I know 11.10.2 says that RREs are not required to report property damage claims unless there's a release of medicals or the effective releasing medicals. And I believed the general release would include release of medicals but like I said in this situation, there really isn't any injury claim.

Barbara Wright: As we've said repeatedly, our touchdown is what's claimed or released or what has the effective releasing medicals. I really don't have an alternative answer to give you.

Pat Ambrose: So in other words, CMS does consider it a property damage only claims if medicals have been released by virtue of that general release.

(Monsour Barmo): OK.

Pat Ambrose: OK. Thank you.

(Monsour Barmo): Thank you, thank you.

Operator: Your next question comes from the line of (Janet Rofter) from Conoco-Phillips. Your line is now open.

(Janet Rofter): Good afternoon and thanks for taking my call. Earlier, you mentioned that the CMS “go-live” dates to the updated system will be the 7th of January. And our reporting week is actually prior to that.

So just sitting here and flicking to the changes in my mind and I – right now, I don’t have any concerns but I – my question is we could be willing to post an alert between now and, you know, early December saying these are the things that are going to be changed on 1/07.

You know, it's this way now and it's going to be this way, that way, if we do have concerns or issues, you know, there are lots of things that are changed and lots of things we keep track of. That way, we wouldn’t miss anything or if we have to confirm, we could call our EDI rep.

Pat Ambrose: Yes. I will definitely take that under consideration and try to put something together. I think it’s a reasonable request.

(Janet Rofter): OK. Thanks. Have a great day.

Pat Ambrose: You, too.

Operator: Your next question comes from the line of (Nikki Laughlin) from (LWCC).

(Nikki Laughlin): Hi. I was calling to see when, you know, you’re going to possibly publish the alerts that we have discussed the couple of calls ago about the reportable TPOCs if ORM is released because from what we understand today, if we’re releasing ORM then we need to report the TPOCs. But if we’re not releasing ORM then we don’t need to report the TPOC. And we’ve looked at the two alerts that were published and we don’t see anything.

Barbara Wright: You’re talking about when there’s a lump sum indemnity payment?

(Nikki Laughlin): Yes, ma’am.

Barbara Wright: OK. We are still looking at that. In fact, we were trying to engage in a conversation with someone on that earlier today so, you know, we do hope to have that shortly.

(Nikki Laughlin): OK.

Barbara Wright: So there were comments at a couple of the earlier calls that we wanted to make sure that we took into consideration.

(Nikki Laughlin): And when we're looking at shortly because we are having some issues because we have to actually code this with our IT department and we're kind of like in this holding mode at this point. So when we say shortly, can we have a definition of shortly?

Pat Ambrose: Shorter than long.

Barbara Wright: I can't give you an exact date. I mean we're working as fast as we can.

(Nikki Laughlin): Should we go ahead and code and not to report indemnity payments?

Barbara Wright: Yes. If I were you, I would because – you know, I would code it to over report rather than under report, and – you know, but that happens to just be the opinion of Pat Ambrose who doesn't necessarily...

(Nikki Laughlin): No. And that's how we had it currently. We had it over report so when it was said, you know, only the reportable TPOC which release medicals, that's when we went into panic mode because we're over reporting technically right now.

Barbara Wright: Yes. Well, I mean that's better. It will get sorted out if there's any kind of, you know, recovery action taken. And then once you see the final rule, you can schedule that for a change in your system as you're able to do so.

(Nikki Laughlin): OK. And then also about indemnity in TPOCs, do you have another alert or would be in the same alert about Worker's Comp indemnity? They've said something in a previous call about – or this call about publishing the indemnity – the Worker's Comp indemnity alert.

Barbara Wright: Well, it's really one in the same.

(Nikki Laughlin): So it is the same, OK.

Barbara Wright: Yes.

(Nikki Laughlin): That alerts then. Thank you.

Barbara Wright: You're welcome.

Operator: Your next question comes from the line of Susan Jones from Pendulum.
Your line is open.

Susan Jones: Hi. Thanks for taking my question. This is regarding the alerts you guys were talking about at the beginning of the call.

I didn't get – I haven't received any of the emails and I looked online and there are the October 14th alerts that are posted but we haven't been receiving emails. What should we do for not getting this?

Pat Ambrose: I would not anything since no one got them.

Susan Jones: OK. I get it.

Pat Ambrose: We're having some issues with that notification.

Susan Jones: OK.

Pat Ambrose: So what I'd recommend is that you very frequently go out and look at not only the homepage but the What's New page and the Alerts page and your NGHP page for any updates.

And we are working on a resolution by the way. The underlying system responsible or used to make those postings is being replaced which is welcome news to me anyway so we should be more consistent in the future with those notifications but that's the current status.

Susan Jones: OK. As far as the – at the beginning, you were talking about change in the DDE date. Did you say January 10th?

Pat Ambrose: Yes, January 10, 2011, you will be able to begin using the Direct Data Entry option on the Section 111 COB Secure Web site.

Susan Jones: And then you're posting an alert to update that change?

Pat Ambrose: Yes. I have obviously a long list. We have a long list of things that we need to get.

Susan Jones: (And they are revised?).

Pat Ambrose: Oh, they have been revised and...

Susan Jones: (I sometimes) (inaudible) it should be up in a few days.

Pat Ambrose: OK. So we have updates to the DDE alerts that are out there. That will be posted very shortly. I wasn't aware of that. OK. So yes, that information will be formally published shortly.

Susan Jones: OK.

Male: Unfortunately, it was the first weekend of the year following a holiday, unless a decision was made that rather than a risk floppy implementation to move that information to the first non-holiday weekend of the year which is why we had to delay for a week, the implementation of DDE, because we want to make sure that all the technical support is available to make sure that release goes out to everyone.

Susan Jones: Yes. I think that was great idea. Thank you.

Pat Ambrose: OK. Thank you.

Operator: Your next question comes from the line of (Rick Woods) from Hanover Insurance. Your line is open.

(Rick Woods): Oh, yes, how are you doing today?

Pat Ambrose: Great.

(Rick Woods): Good. One of the questions I wanted to ask was regarding – I know you're saying that we needed to monitor injured parties and so they become Medicare eligibles as long as their claims are still open.

I'm speaking more to the ORM side. Say, if you have a situation where we monitor someone for 10 years and they finally become eligible after 10 years. Our claim is still open. We're in a lifetime medical state. What ICD-9 code should we be putting in for that claim?

Pat Ambrose: The ICD-9 and later when we convert to ICD-10 will be related to or what will be due is you'll be submitting an Add Record so you'll have to use diagnosis codes that are valid at the time that that Add Record is submitted.

And I understand where you're headed here, so you'll have to do – if you associated an ICD-9 and we're no longer accepting those 10 years from now, you'll have to crosswalk them to an ICD-10. And, you know, we'll definitely take it under consideration to see what we can do to help you with that.

We've said in the past that if your record is already been submitted and accepted then you don't have to worry about changing it, but new records, and this would be considered a new record to us, would be under the, you know, current list of valid diagnosis codes being used at that date.

(Rick Woods): I guess, one of the things that I just wanted to get a little bit more further clarification on, so say for the claim happened in 2000 and I'm reporting in 2011 because they become Medicare-eligible in the year 2011. When I go back all the way to 2000 to answer those ICD-9 codes for the beginning of the claim?

Pat Ambrose: Well, you know, the ICD-9 codes that you're submitting are to describe the illness injury claims, alleged, incurred...

John Albert: We will be paying.

Pat Ambrose: And that you have assumed ongoing responsibility for medical for, so it's – you know, you ever had and I'm looking around the room here. If you have – at the time of the report, should they only report the diagnosis codes for the ORM that they currently have.

Barbara Wright: Let's put one of the examples. There's a situation where originally there were three body parts affected. And for whatever reason or however, you got a

relief with respect to body part one so you're only – you only now have ORM for two body parts. Report the ICD-9 codes or what – if it's ICD-10 or whatever at that time, report the codes for the ones that you have current ongoing responsibility for.

That's just like we were saying now, if you originally report ORM with five codes and the same thing would happen in the future, we've said that you can come in and remove the code that you're no longer paying for. So that – you know, the two answers I think are consistent.

John Albert: I mean, the purpose of getting an accurate code set at the time the person has become a beneficiary is not so much a simple recovery but for ensuring that claims coming in the door are properly paid. We don't want, you know, the Medicare claims payment contractors to be denying claims for which there really is no other responsible party. So in Barbara's example, we would not want that just for that reason alone.

(Rick Woods): Thank you, guys, very much. I appreciate it.

John Albert: All right.

Operator: Your next question comes from the line of Peter Gunn from Applied Underwriters. Your line is now open.

Female: Hi. Thank you. I have a question regarding the special exceptions regarding reporting of choice of ORM on the User Guide. The User Guide indicates that RREs may submit a termination date for ORM if they've got a signed statement from the treating physician that the clinic will prior new further medical items or services associated with the claim. And I have a couple of questions regarding this.

First of all, I would like to know if the physician has to actually state that no further medical services are required or it's a simple discharge of the (lease from) care without adjusting future medical needs on a minor injury acceptable. We've noticed that the most medical reports regarding minor injuries do not address future medical. They just simply are released from care.

Barbara Wright: The problem with the general release from care is the fact that one doctor is releasing them doesn't mean that they're not continuing to receive care for that injury from another doctor. So unless, you know, you've got a medical certification that that injury has been released from care, we have a concern with that.

Female: OK. And I also was wondering would a relief from an independent medical examiner assigned by the carrier or by the state be considered a treating physician with the scope of the exception?

Barbara Wright: We know no reason to consider them as such. By title alone, there's someone who's evaluating and examining. They're not someone who's dealing with the person's actual treatment.

Female: OK. OK. Thank you.

Operator: Your next question comes from the line of (Aneka Luth) from Mutual. Your line is open.

(Aneka Luth): Hi. Thank you. I have a question on ICD-9 codes. Previously when V-codes were allowed as a diagnosis code, we had to have second diagnosis code that did not start with the V. And then currently, all V-codes are excluded. But in version 28, we have some V-codes again. So the question is, can V-codes stand alone or if we use one, do we have to use a secondary code?

Pat Ambrose: All those versions are – will continue year-after-year to include V-codes or – V as in Victor codes, starting with the letter V but we will not accept those codes for section 111 reporting.

So you start with the files on the CMS website but you must remove the excluded codes in Appendix H and you must also remove the V-codes – V as in Victor codes as well.

(Aneka Luth): Great. That's all I needed. Thank you.

Pat Ambrose: OK.

Operator: Your next question comes from the line of (Barbara Whitfield) from Fireman Insurance Company.

(Barbara Whitfield): Good afternoon. I don't know – all right. I just want to make sure you could hear me.

Pat Ambrose: Yes, (we can).

(Barbara Whitfield): All right. So my question relates to the – one of the alerts on October 14th as they relate to the word "cumulative injury", and I wondered if you could provide us with a definition related to that.

Barbara Wright: We don't have a specific medical definition. We were asked about situations, for instance, like carpal tunnel syndrome or when someone had general back problems that wasn't – that weren't necessarily trauma-induced, that we had more than one inquiry from members of the industry – what about injuries that essentially are cumulative before they're actually diagnosed or treated. And so that's the sense in which we use the term.

Male: Yes.

(Barbara Whitfield): So, for example, if a person was exposed multiple times to asbestos products, you would consider that to be a cumulative injury?

Barbara Wright: That's an exposure injury. That's not – a cumulative injury, they were asking about a cumulative physical injury as opposed to an exposure case.

(Barbara Whitfield): OK. That's what I wanted to know.

Barbara Wright: OK.

(Barbara Whitfield): Thank you.

Barbara Wright: And so – no, we wouldn't consider exposure to be a cumulative injury.

(Barbara Whitfield): Thank you.

Operator: Your next question comes from the line of (David Chiong) from City of Los Angeles. Your line is open.

(David Chiong): Can you hear me?

Barbara Wright: Yes.

(David Chiong): Hey, can you hear me?

Barbara Wright: Yes.

(David Chiong): OK. Yes, my question is that there is a lot of reference about contacting the EDI rep that you have any problems. And my question is, what if I'm not getting a prompt response from the EDI rep. And right now, we're on a testing status and we're trying to go onto production but we're getting a lot of errors and, you know, putting in a lot of manpower but at the same time, we're not just getting any response back from them.

Barbara Wright: Well, there is an escalation process in section 18.2 of the User Guide where you may contact Mr. Bill Ford and subsequently, Mr. Jim Brady or actually, it's Jeremy Farquhar first, then Bill Ford, then Jim Brady. But there are other people waiting to help you if you need to have your issue escalated, so I would highly encourage you to follow those procedures and move it on up the chain.

(David Chiong): Wait, I mean I – can I ask another question?

Barbara Wright: The speaker – before you go on, I just need to state that we do not have a lot of folks escalating issues, so – and I have mentioned it on the last few calls. So either folks are not following those instructions in 18.2 or there aren't a lot of issues that require escalation. So at any rate, that's where you can find information on how to go about that.

(David Chiong): Yes. It's always the escalation. I did do that. But problems that, you know, normally I have to do that for him to respond to me and usually, when he respond he responds by email. And if I have a follow-up question, it takes

another two or three days for him to get back to me. So I'm looking at about a month's time for two questions to be answered.

Barbara Wright: OK. We'll take that under consideration, take it back to the (CODC) and work through that issue to improve that turnaround.

Male: Get the ID number.

Barbara Wright: Can I get your RRE ID number please?

(David Chiong): Sure. It's 14222.

Barbara Wright: OK. Thank you.

(David Chiong): Thank you.

Barbara Wright: We'll follow-up with you.

Operator: Your next question comes from Jim McMorrow from PgE. Your line is open.

Jim McMorrow: OK. I guess, so I was going to ask about the TPOC but it sounds like you're still working on it. But for worker's comp purposes in California, there is one wrinkle to your deciding on – for instance, in California essentially, there will be three types of settlement. One is called the compromising release where all benefits are released and that's clearly a TPOC. You can also rarely get into a situation where there's a compromising release, which is a lump sum payment for all benefits but future medical so the agreement is we're settling all the indemnity claims, but we are still – we still provide future medical. So that probably to me sounds like at TPOC also.

But the third and more traditional type of settlement is what's called stipulations where you're just agreeing on the percentage of disability which is paid over time until the employee dies and an agreement that there is – that we will have ORM. In other words, there is future medical.

So if you're leaning towards considering that third type of settlement A TPOC, there's going to be problems with identifying the actual sum because there are

cost of living adjustments to those payments over time, so it will – it would be hard to tell what the sum is for that settlement.

Barbara Wright: The example you give for number three where you said there are future medicals...

Jim McMorrow: Yes.

Barbara Wright: ...are you paying those future medicals on ongoing basis?

Jim McMorrow: Yes, they do.

Barbara Wright: OK. Well...

Jim McMorrow: Right. It's always subject to – it always has to be tied back to the claim if they can't tie it back to the actual injury then even if it's the same body part was going on that but...

Barbara Wright: So for your first compromising release, all you had would be a TPOC payment. For your second one with all the future medicals, you would have continuing ORM. And for your third example, you would have continuing ORM. Correct?

Jim McMorrow: Correct. And ongoing indemnity payments as well that will not – that are not a lump sum payment.

John Albert: And you've set an example is your TPOC including payments for medicals prior to the day of the agreement.

Jim McMorrow: No. It's just for – you know, you can agree whether it's 20 percent disability or 70 percent, so you settle at 45 and pay it as a lump sum...

John Albert: OK.

Jim McMorrow: ...rather than every two weeks which is...

John Albert: When you say future medicals, you're also including medicals that again not – that may have been given – provided in the past but not – have not yet been billed to you.

Jim McMorrow: Yes. So it's past and future medical is being paid.

John Albert: OK. So that's an important distinction as to whether it's only future medical and the TPOC prepare the old medicals.

Barbara Wright: So both your second and third example to the extent there's a TPOC, there's also continuing open ORM.

Jim McMorrow: Correct.

Barbara Wright: OK.

Jim McMorrow: All right. So you would say that that – that those would be only reported as ORM, or you haven't decided yet?

Barbara Wright: I would say we will address it in the alert.

Jim McMorrow: OK. And then I need to make a comment about one of the prior calls – questions on discharged from care. In California, the physician writes the words you were discharged from care that means legally that you – the doctor's opinion is there's no future medical. And this case law that and "the injured worker is not allowed to change treating physicians until they go through a dispute resolution process if they disagree with that physician's statement that there isn't – that they're discharged from care.

So what you said on the phone is that one physician's opinion may not be the same, which is true, I'm not denying that, otherwise we would have claims. And – but there are some laws out there that prevent the employee in the context of the worker's comp claim from seeking a second opinion. Of course, they're free to go out and pay a doctor on their own and, you know, put it to a health insurance or something but they're not allowed to change doctors. To challenge that opinion, they have to go through a dispute

resolution process which involves selecting other doctors to decide the issue.
So I just wanted to point that out.

Barbara Wright: If you want to send us some detail in the mailbox, we'll take another look at it. In general, we need to give you bright-line rules. We cannot craft the rule to meet every specific states' considerations.

Jim McMorrow: Right.

Barbara Wright: We can look at the issue of whether or not if state law is specific enough, the certain language definitively releases the injury that's being claimed, would we accept that? Yes. We'll look at something like that if you can explain it clearly on what you send in.

Jim McMorrow: Well, I don't mean to imply release as anything. But let's say it's a, you know, someone gets four stitches in their finger and the doctor treats them and then discharges them from care. That file closes. There's no release. There's no anything and there's certainly no agreement that we're going to be responsible for ongoing medical. If the employee tries to get more medical, then they would deny that and send a letter saying, you have to go to this process if you want a challenge the treating physician's opinion that you were discharged. So there is no settlement. There's no release. The files just closed.

Barbara Wright: And they've closed based on what – a specific state law that says that...

Jim McMorrow: Based on the fact that there's no benefits due – no more benefits due to the employee.

Barbara Wright: And you're basing that upon the discharge document.

Jim McMorrow: Based upon the treating physician's employee – I mean, the employee's treating physician who said they don't need any more care.

Barbara Wright: Well, again, if you'd like us to consider that, I think you need to write in and tie how that would be tied to a specific state law, why that constitutes a release

or – not a release, using a wrong word there, why that constitutes sufficient documentation that you are legally entitled to close that claim.

Jim McMorrow: Well, I would never – we're never required to keep a claim open if no benefits are due, not so basic premise of claims but often you already know.

Barbara Wright: OK. Thank you.

Jim McMorrow: All right. OK. That's all I have.

Operator: Your next question comes from (Shawn Downey), (Jones Easter). Your line is now open.

(Shawn Downey): Yes, I was calling to ask if you're experiencing delays. We've had a problem in two months in a row where our query files were not picked from the SFTP site and processed them. We had to alert our EDI rep about this. About 70 percent – we handled over 70 RREs with TPA and about 70 percent of them were not picked up in late September and then all of them were missed for our submission that we did on November 3rd.

And I'm just wondering, we've built in calendars and due dates and what not in our system based upon, you know, having a fairly reliable dating to get back the query files in time to get in the claim input files in timely manner. And we're just wondering if you're experiencing problems and what we can do to, you know, alleviate this if there's anything.

Pat Ambrose: Well, we continue to work on stabilizing the SFTP environment. Some changes have been made. Also, as far as, you know, process and the timeliness of processing, query files certainly were committed to returning those query files within the timeframe documented.

I am afraid we don't have anyone in the room today that can speak to a particular technical issue on a particular day. But, you know, your concern is certainly duly noted and we'll follow up.

(Shawn Downey): Thank you. Thank you. We just – we had a delay in getting in our September file so then that delay on the other side has then being picked up. They didn't

get counted into October and it just, you know, we are concerned about the warning messages going out and what not. And, you know, as we're getting closer to the data going live with claim input production on that, we were little concerned. Thank you.

Pat Ambrose: Yes. I completely understand. OK. Thank you.

(Shawn Downey): Yes.

John Albert: Again, for folks on the call, if you are having trouble, of course, alert your EDI rep as soon as – as you're aware of a potential issue. The files you're expecting, you don't receive them, please, you know, get on the phone and contact them.

And again, as Pat mentioned, if you're not getting a timely response, please utilize the escalation process. Also, people are going to submit comment to the resource mailbox as well and just another way for us to keep hands on things. But as we've mentioned, we are aware that there have been some temporary shutdowns of the process for various reasons. Most of them has been resolved very quickly.

Some of the steps that we're trying to do is to provide outreach on the – or messaging on the secured website itself, on the Bulletin Board feature whatever you want to call it to let people know that we're experiencing a temporary problem – things like that. So again, just stay in touch with us and that will help us identify where the issue may be or whatever and hopefully, you know, make it as stable as possible come January.

(Shawn Downey): Thank you.

Operator: Your next question comes from the line of (Rose Nelly) for Corporate Claims.

(Rose Nelly): We have a question on the TPOC. On the denied case that goes to either trial or dismissed, which – what do you put for the TPOC date and amount? And on the trial, the case has been affirmed to be denied and then the dismissal, of course, would be zero amount also.

Pat Ambrose: It doesn't sound like the claim is reportable. If there, you know, there was no settlement amount – no TPOC amount.

Barbara Wright: I mean, did you ever make payment on this. I mean, I thought the User Guide had a specific statement about the vendor appeal.

(Rose Nelly): No, no payments were made so we are going to put no for the ORM. And then if we have an award and a dismissal, should we put anything in the TPOC date and amount?

Barbara Wright: And what do you mean by an award and dismissal? That's ultimately some type of payment, right?

(Rose Nelly): No. An award, meaning that they affirm the denial that no payments will be made and the dismissal is also that no payment...

Barbara Wright: OK. If you have never assumed ORM and you have never made any TPOCs and you end up with what do you call the defense verdict or it's officially called an award with no payment or whatever, if there is never going to be any payout whatsoever then you're not going to be recording that case.

(Rose Nelly): OK.

Barbara Wright: Does that help or...

(Rose Nelly): Yes. So we don't put a TPOC date or amount, just put no for ORM.

Pat Ambrose: You would have report it at all.

(Rose Nelly): Right, because of the end of the threshold.

Pat Ambrose: Right.

(Rose Nelly): OK. Thank you.

Pat Ambrose: You're welcome.

Barbara Wright: And through ORMs, since you didn't assume ORM, you're not reporting ORM.

Operator: Your next – go ahead.

Pat Ambrose: Oh, I'm sorry, operator. If I could interrupt you just for a minute, we did talk earlier that we saw some RRE submitting an ORM indicator equal to N and also – and submitting zeros in all the TPOC fields and that is not a valid condition. So it kind of goes to the last question that we had.

OK. I'm sorry, operator. Please proceed.

Barbara Wright: I'm sorry. I do have one thing to add to what Pat was saying. If you have a situation where you have – as I was called at one point a defense verdict. If the defense verdict for the entire case is for the entire case, you're not paying anything at all. Then what we said about not reporting ORM because you didn't assume it, not reporting a TPOC because there isn't one is correct.

But keep in mind, we've said that we're not bound by allocations to the parties. If there's some type of quote defense verdict unquote or defense agreement that the insurance entity or worker's compensation is quote not liable unquote but there are some type of settlement and it's quote allocated to something other than medical, that still need reported if it's just an allocation.

If there is a determination on the merit like, for example, a jury trial that there are no medical, then we will respect that jury verdict and you don't have to report medicals. So do keep in mind, you know, the variation whether you're talking about a situation where it's the allocation that makes it zero or there's truly no payment whatsoever.

Operator?

Operator: Thank you. Your next question comes from the line of (Richard Schoenberg) from (ALSTI). Your line is open.

Male: Come on.

Female: Just wanted to find out if a descendant as opposed to an insurance carrier is considered an RRE.

Barbara Wright: You need to read through the section in the User Guide about who is the RRE. There are certain situations where the defendant is actually self-insured or where there's insurance but we're dealing with say, a fronting policy or a stop-loss. We put the rules in the User Guide. You really need to read through those again and apply them to your specific factual situation. I can't give you a flat yes or no unfortunately.

Female: OK. Safe to assume then as it's not listed in the User Guide a...

Barbara Wright: You need to apply the rules that are there. We – there's no way that we could come up with every single possible combination and situations. What we've done is set down bright-line rules and you need to apply them with specific facts in your situation.

Female: OK. Thank you.

Operator: Your next question comes from the line of (Sarah Towney) from RLI Insurance. Your line is open.

(Sarah Towney): Good afternoon.

Female: Hello.

(Sarah Towney): Hello. Just making sure you can hear me.

If a Med Pay ORM policy limitation run out prior to January 1, 2010 but due to the administrative error, the ORM file remains open on and/or after January 1, 2010 despite they are no longer being any funds available, is the claim still reportable?

Pat Ambrose: Well, technically, you didn't have ORM after – I mean, specifically, you did not have ORM after January 1, 2010.

(Sarah Towney): Correct.

Pat Ambrose: And the claim is not reportable.

(Sarah Towney): Thank you.

John Albert: Operator, any more questions?

Operator: Yes. Your next question comes from the line of Deanna Wilcox from Covington & Burling. Your line is now open.

Deanna Wilcox: Hi. Thank you for taking my question. This has to do with self-insured status in a situation where we have a defendant company in (one peril) toxic tort type claim. The defendant pays the plan of the settlement in the first instance but then turns around and bills its insurers often presented to a coverage in place agreement where the insurers have agreed to pay a percentage often based on, you know, an allocation formula.

So in that instance, I have read the User Guide and it appears to me that the company that pays the judgment or settlement in the first instance would be the RRE and they would, I think, report themselves as a self-insured with their own, you know, TIN in the appropriate field and so forth and so on. And I just really wanted some confirmation that that analysis is correct.

Barbara Wright: I don't think we've seen any written questions that actually get in to the details of the coverage in place. I would say based on your description that you've given right now, we would tend to generally agree but in most of the verbal explanations we get half the time, there's a few facts that are left out which may or may not be vital to the decisions. So – I mean, we can give you a qualified yes right now. It generally sounds like you're following the right thought process.

Deanna Wilcox: I did submit that question to the mailbox pretty much...

Barbara Wright: Can you resubmit it?

Deanna Wilcox: Absolutely, pretty much the way I just laid it out but I will certainly send that back in.

Operator: Your next question comes from the line of (Joey Ward) from Empire Pacific Risk Management. Your line is now open.

(Joey Ward): Yes. My question is in regards to the \$750 threshold for worker's comp medical-only claims. Many states where ORM does not terminate those lifetime medicals, so my understanding is that on December 31, 2011, that exclusion ends after that point. Are we required to report all the claims previously excluded because ORM remains open or will it be like a qualified exception that says if they were administratively closed prior to 1/1/12 and they're under that threshold, can they be excluded still?

Barbara Wright: We're not asking people to go back and change. If it met the requirements for the ORM threshold at the time the payments occur, we're not asking people to go back and reopen those.

(Joey Ward): OK. That's all. Thanks.

Operator: Your next question comes from the line of Randy Haynes from MRC. Your line is open.

Randy Haynes: Hi. I just wanted to clarify one issue regarding clinical trials. Since reporting these ORM, we're not actually reporting when a company is assumed only when payments are made, is that correct?

Barbara Wright: No. You should be reporting when you assumed responsibility. And then like any other ORM, you don't report the specific dollar payments.

Randy Haynes: I think where the confusion is coming from is in the alert that was issued that said when clinical trial payments are made and that's what we've been going off of. So I – and that was the conflict I saw with calling an ORM if it's only when payments are being made.

John Albert: We...

Barbara Wright: Could you send the comment to the mailbox and not only point out the specific language you're talking about? But if you have suggested replacement language, put that in your note as well.

Randy Haynes: Both for now, we should assume that we are going to be reporting when the obligation is assumed, not just when payment is made for an injury.

Barbara Wright: Right. And it should be reporting the ICD-9 codes that are associated with the injury or complication that you have assumed responsibility for.

Randy Haynes: Sure, sure.

Barbara Wright: OK.

Randy Haynes: All right. Thank you.

Operator: Your next question comes from the line of (Bonnie Mustard) from Farmers Insurance. Your line is open.

(Bonnie Mustard): I have a question regarding – I had put in a suggestion for claimant beneficiary. This is basically the claimant beneficiaries who do not want to provide (inaudible) or other appropriate information that we can report. And what – you've already identified to us that we should – this occurs and report the Medicare beneficiary as if those are not deceased and not provide the additional information that we maintain in our claim file.

But part of the thought process behind this suggestion is that we're getting comments from people who, you know, again are not certain about should they give their social security number, why it's needed, etc.

Male: I'm not sure what your actual question is right now.

(Bonnie Mustard): I had submitted a request for you to issue an alert on claimant beneficiary or to the alert they have been issued for Medicare beneficiaries, explaining to them why there the social security is needed in the cases where there are claimant beneficiaries for Medicare beneficiaries who is deceased.

Male: OK. We can take that under consideration.

(Bonnie Mustard): I could resubmit that if you'd like.

Pat Ambrose: Sure. That will be great.

(Bonnie Mustard): I will send it in again right now. Thank you.

Male: OK. So – and just to verify when you're talking claimant here, you're talking claimant as we define it for purposes and the like, someone who is a representative of an estate, etc., not the injured party.

(Bonnie Mustard): Absolutely. That's exactly what (inaudible).

Male: OK.

John Albert: OK. So – again, a more specifically tailored example for that situation other than what we have out there right now, which are more than the general suggestive language for – that you should use when, you know, trying to collect that information so we can report it to (inaudible).

(Bonnie Mustard): Right. There is nothing really to explain to a claimant beneficiary but in order to report when the Medicare beneficiary is deceased then we're reporting the payment of the – to the trust or to those people, you know, there's really nothing to explain to them that you are required to have your social security number for that reporting.

John Albert: And this – and I'll just say just as anyone on the call that, you know, again, we're always looking for suggestive model language that we can use and share because, you know, we're dealing with a lot of different unique situations. And so whatever, you know, we're really are looking for input in terms of constructive input in terms of, you know, actual examples of language that we could use to, you know, as a model language for industry or what not to assist in collecting that information. So anything you can provide in terms of in writing would be great.

(Bonnie Mustard): OK. All right. I'll add something to this.

John Albert: Thank you.

Operator, we have to – now three o'clock Eastern Time, we have to end this call. I'd like to thank everyone for their presentation. Continue to submit your questions, you know, it's helpful we've demonstrated. We're trying to answer many of those written questions that's submitted to the Resource mailbox on this call, as well as provide other information.

Barbara did mention earlier to keep an eye out for pending alerts coming out in the very near future. And with that, thank you, everyone and we'll talk to you in December.

If, operator, you can stay on the line after (snipping) the call. Thanks.

Female: Thanks.

Operator: This concludes today's conference call. You may now disconnect.

END